Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH ALLEN
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name
UTICA MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-3066-01

MFDR Date Received
MAY 10, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 143% of DRG for inpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $10,978.57 for DRG 494 at 143%. Based on their payment of $9,698.36, a supplemental payment of $1,280.21 is due."

Amount in Dispute: $1,280.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pursuant to the enclosed notice, please find enclosed the Beech Street provider contract requested. Please note that because no PPO discount was taken, the reimbursement exhibits are not included."

Response Submitted by: MultiPlan

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2010 through August 21, 2010	Inpatient Hospital Surgical Services	$1,280.21	$1,280.21

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits

- 247-This service, supply, or material is either inclusive or not separately payable.
- 353-This charge was reviewed per attached invoice.
- 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 45-Charges exceed your contracted/legislated fee arrangement.
- 468-Reimbursement is based on the medical hospital inpatient prospective payment system methodology.
- 793-Reduction due to PPO contract.
- B12-Re-evaluated; Additional payment is recommended.
- W1-Workers compensation state fee schedule adjustment.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- B13-Re-evaluated; no additional payment is recommended.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
3. Which reimbursement calculation applies to the services in dispute?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason codes "45 and 793.". Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 21, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).
3. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).
4. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 494, and that the services were provided at Texas Health Allen. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $7,677.32. This amount multiplied

by 143% results in a MAR of $10,978.56.

5. The division concludes that the total allowable reimbursement for the services in dispute is $10,978.56. The respondent issued payment in the amount of $9,658.36. The difference between the MAR and amount paid is $1,320.20. Based upon the documentation submitted, the requestor is seeking additional reimbursement in the amount of $1,280.21. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,280.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/17/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.